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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES—CENTRAL DISTRICT

Victor Avalos, an individual; A.G., a minor through his Guardian ad Litem, Carlos Garcia; R.O., a minor through his guardian ad litem, Maria Barron; D.O., a minor through her guardian ad litem, Maria Barron; B.L., a minor through her guardian ad litem, Maria Barron; D.L., a minor through his guardian ad litem, Maria Barron; N.L., a minor through his guardian ad litem, Maria Barron; Estate of Anthony Avalos, through special administrator David Barron,

Plaintiffs,

vs.

County of Los Angeles, a public entity; Hathaway-Sycamores Child and Family Services, a private non-profit, public benefit 501c(3) corporation; Mark Millman, an individual; Anna Sciortino, an individual; Shane Bulkley, an individual; Ikea Vernon, an individual; Mishi Wasse, an individual; Gabriela Robles, an individual; Michelle Thomas, an individual; and DOES 1 through 100, inclusive.

Defendants.

Case No.

COMPLAINT FOR DAMAGES

1. **Wrongful Death (CCP §377.60)**
2. **Negligence sounding in wrongful death**
3. **Gross Negligence sounding in wrongful death**
4. **Negligent Supervision sounding in wrongful death**
5. **Negligent Hiring and Retention sounding in wrongful death**
6. **Violation of Civil Rights (CCP §52.1) sounding in wrongful death**
7. **Negligence (Mandatory Duty)**
8. **Gross Negligence**
9. **Negligent Supervision**
10. **Negligent Hiring and Retention**
11. **Violation of Civil Rights (CCP §52.1)**
12. **Survival Action (CCP 377.34)**

DEMAND FOR JURY TRIAL

I. INTRODUCTION

Ten-year-old Anthony Avalos was allegedly murdered on June 21, 2018 by his mother Heather Barron and her boyfriend Kareem Leiva. In addition to Anthony, his six half siblings also lived in the home with Barron and Leiva. Anthony's death occurred after years of reports of abuse were made to the Los Angeles County Department of Children and Family Services. Barron has been charged with murder, child abuse resulting in death, and torture while Leiva has been charged with murder, torture, and assault on a child causing death.

Plaintiff Victor Avalos brings this action under the provisions of California Code of Civil Procedure §377.60.

II. VENUE AND JURISDICATION

1. Venue is proper in the Superior Court of the State of California, for the County of Los Angeles, Central District, in that the underlying wrongdoing, acts, omissions, injuries, and related facts and circumstances upon which the present actions is based occurred in the City of Lancaster, County of Los Angeles, California, within the judicial boundaries of the Central District of this Superior Court. This Superior Court has jurisdiction over the present matter because, as described herein, the nature of the claims and amounts in controversy meet the requirements for unlimited damages jurisdiction.

2. Plaintiffs have exhausted their administrative remedies by duly and properly filing proper notices of claim pursuant to the Government Claims Act (California Government Code Section 911.2 *etc. et. seq.*). Defendant County of Los Angeles has notified Plaintiffs that Plaintiffs' claims were received and under investigation. No further response has been given to Plaintiffs following the 45-day statutory notification period.

III. PARTIES

3. At all relevant times, Plaintiff Victor Avalos was an individual residing in Mexico and the biological father of decedent Anthony Avalos.

4. At all relevant times, minor Plaintiff A.G. was a minor child residing in the County of Los Angeles, State of California. Carlos Garcia is A.G.'s biological father, and is A.G.'s guardian ad litem for purposes of this lawsuit.

5. At all relevant times, minor Plaintiff R.O. was a minor child residing in the County of Los Angeles, State of California. Maria Barron is R.O.'s aunt, and is R.O.'s guardian ad litem for purposes of this lawsuit.

6. At all relevant times, minor Plaintiff D.O. was a minor child residing in the County of Los Angeles, State of California. Maria Barron is D.O.'s aunt, and is D.O.'s guardian ad litem for purposes of this lawsuit.

7. At all relevant times, minor Plaintiff B.L. was a minor child residing in the County of Los Angeles, State of California. Maria Barron is B.L.'s aunt, and is B.L.'s guardian ad litem for purposes of this lawsuit.

8. At all relevant times, minor Plaintiff D.L. was a minor child residing in the County of Los Angeles, State of California. Maria Barron is D.L.'s aunt, and is D.L.'s guardian ad litem for purposes of this lawsuit.

9. At all relevant times, minor Plaintiff N.L. was a minor child residing in the County of Los Angeles, State of California. Maria Barron is N.L.'s aunt, and is N.L.'s guardian ad litem for purposes of this lawsuit.

10. At all relevant times, decedent Anthony Avalos was a minor child residing in the County of Los Angeles, State of California. The Estate of Anthony Avalos was created by the probate court in the Central District and the Hon. Paul T. Suzuki ordered that David Barron, the uncle of Anthony Avalos, be appointed special administrator of the Estate of Anthony Avalos.

11. At all relevant times, Defendant County of Los Angeles, ("County") is a public entity organized, existing, and conducting business under the laws of the County of Los Angeles and the State of California. County is the employer and principal of all individuals employed by Los Angeles County Department of Children and Family Services ("DCFS") that came into contact with decedent Avalos and minor plaintiffs. The instant case demonstrates the custom and practice of deliberate indifference towards children by the agency.

12. At all relevant times, Defendant Hathaway-Sycamores Child and Family Services ("Hathaway") was a private non-profit, public benefit 501c(3) corporation which operates and manages its business locations from its headquarters in Pasadena, CA, County of Los Angeles and the State of California. Hathaway is the employer of all individuals employed by Hathaway that came into contact with decedent Avalos and minor plaintiffs.

13. At all relevant times, Mark Millman ("Millman") is a social worker employed by the Los Angeles County DCFS. He is sued in his individual capacity.

14. At all relevant times, Anna Sciortino ("Sciortino") is a social worker employed by the Los Angeles County DCFS. She is sued in her individual capacity.

15. At all relevant times, Shane Bulkley ("Bulkley") is a social worker employed by the Los Angeles County DCFS. He is sued in his individual capacity.

16. At all relevant times, Ikea Vernon ("Vernon") is a social worker employed by the Los Angeles County DCFS. She is sued in her individual capacity.

17. At all relevant times, Mishi Wasse ("Wasse") is a social worker employed by the Los Angeles County DCFS. She is sued in her individual capacity.

18. At all relevant times, Gabriela Robles ("Robles") is a social worker employed by the Los Angeles County DCFS. She is sued in her individual capacity.

19. At all relevant times, Michelle Thomas ("Thomas") is a social worker employed by the Los Angeles County DCFS. She is sued in her individual capacity.

20. Defendants DOES 1 through 50, inclusive, are the agent, employee, supervisor, employer, servant, principal, partner, joint-venturer or co-conspirator of County, and each was at all times alleged herein acting within the course and scope of his or her employment and with the express authority, ratification, knowledge and consent of his or her employer and/or supervisor. County and DOES 1 through 50 were in some way responsible for the harm that was sustained by decedent and Plaintiffs as alleged herein and/or cooperated and/or facilitated or contributed to the harm suffered by Plaintiff as alleged herein. County and DOES 1 through 50 also knew and/or should have known and/or were put on notice of the actions of each and every other Defendant listed as DOES 1 through 50 which caused harm either directly or indirectly to each of the Plaintiffs as herein alleged and failed/refused to take act action to prevent the harm alleged herein from occurring.

21. DOES 1 through 25 are employees/agents of, or consultants to County, working at all relevant times under the direction, supervision, and control of County. Defendants DOES 26 through 50 are employees/agents of County working at all relevant times under the direction, supervision, and control of County in managerial, supervisory capacities.

22. Defendants DOES 51 through 100, inclusive, are the agent, employee, supervisor, employer, servant, principal, partner, joint-venturer or co-conspirator of Hathaway, and each was at all times alleged herein acting within the course and scope of his or her employment and with the express authority, ratification, knowledge and consent of his or her employer and/or supervisor. Hathaway and DOES 51 through 100 were in some way responsible for the harm that was sustained by decedent and Plaintiffs as alleged herein and/or cooperated and/or facilitated or contributed to the harm suffered by Plaintiffs as alleged herein. Hathaway and DOES 51 through 100 also knew and/or should have known and/or were put on notice of the actions of each and every other Defendant listed as DOES

51 through 100 which caused harm either directly or indirectly to each of the Plaintiffs as herein alleged and failed/refused to take action to prevent the harm alleged herein from occurring.

23. DOES 51 through 66 are employees/agents of, or consultants to Hathaway working at all relevant times under the direction, supervision, and control of Hathaway. DOES 67 through 100 are employees/ agents of Hathaway working at all relevant times under the direction, supervision, and control of Hathaway in managerial, supervisory capacities.

IV. FACTS COMMON TO ALL CAUSES OF ACTION

24. Decedent Anthony Avalos was the child of Heather Barron and Victor Avalos. At the time of his death he lived with his six half siblings, mother Barron and Barron's boyfriend, Leiva. His half siblings are A.G. (GAL Carlos Garcia), D.O. and R.O. (GAL Maria Barron), and N.L., B.L., and D.L. (father Kareem Leiva). At the time of Anthony's death, the only father who had given up his parental rights over his children was the father of D.O. and R.O.

25. The Los Angeles County Department of Children and Family Services ("DCFS") is a child welfare agency that is required by state law to investigate allegations of abuse and neglect. Beginning in February 2013, DCFS received the first call reporting allegations of abuse involving Anthony Avalos. From February 2013 until the time of his death on June 21, 2018, there were at least 13 reports of abuse and neglect involving Anthony and his half siblings. As will be detailed below, several of these allegations were deemed substantiated. The instant case demonstrates the custom and practice of deliberate indifference towards children by the agency. The Child Abuse and Neglect Reporting Act includes California Penal Code 11165.9. Section 11165.9. DCFS, and by extension the County, owed a statutory duty pursuant to California to receive all reports of reported child abuse and to report substantiated allegations of abuse to the Department of Justice.

26. Hathaway-Sycamores Child and Family Services (Hathaway) is a private social services agency that provides social services to at risk families through its contract with DCFS. Hathaway provided in home services for Barron, Anthony, and one of his half siblings beginning in February 2015, which lasted six to nine months. Counselor Barbara Dixon ("Dixon"), an employee of Hathaway, was assigned to work with Anthony and the family. Barbara Dixon was also the counselor assigned to Gabriel Fernandez, another young boy that was killed by his mother and her boyfriend in 2013. At a preliminary hearing in the Gabriel Fernandez case, Dixon testified after she was granted immunity. At the hearing, Dixon admitted to not disclosing the abuse of Gabriel Fernandez to DCFS at the direction of her supervisor.

Q: So one of those requirements was that when you observed injuries, you were to call the DCFS hotline; is that correct?
A: I was to discuss it with my supervisor.
Q: You believed that your duties as a mandated reporter were to discuss it with your supervisor?
A: Correct.
Q: Not to call 911 or the DCFS hotline?
A: Correct.
Q: And was that your custom and practice while working at Hathaway Sycamore?
A: Yes.
Q: So whenever you observed injuries on a case that you - - whenever you observed injuries on a child abuse case you were servicing, you would first discuss with your supervisor whether this was something that needed to be reported to the DCFS hotline?
A: Correct.
Q: So if your supervisor said, 'Ms. Dixon, don't report these injuries to the hotline,' you follow that directive?
A: Correct.

Plaintiffs believe that Dixon also failed to report signs of abuse of Anthony in the instant matter. Hathaway's actions in the Fernandez case and its aftermath placed Anthony directly in harm's way. Hathaway continued to use Dixon and assigned her to be Anthony's therapist. Hathaway should have immediately removed Dixon after

Gabriel Fernandez was murdered and conducted an audit of all the cases she had been assigned to in order to see if there were other occasions where she failed to report suspected child abuse. Hathaway has implemented a policy that violated California mandated reporter laws. The Child Abuse and Neglect Reporting Act includes California Penal Code 11165.9. Section 11165.9. Hathaway owed a statutory duty pursuant to California to receive all reports of reported child abuse and to report substantiated allegations of abuse to the Department of Justice.

27. Unfortunately, the 2013 torture and murder of Gabriel Fernandez was not the first or the last taking place by a child in the DCFS system. In particular, the Lancater/Palmdale DCFS office has a custom and practice of egregious behavior that has led to the murders of several children. In 2013, there was Gabriel Fernandez who was tortured and murdered by his mother and her boyfriend following countless red flags of physical and sexual abuse that DCFS social workers knowingly failed to properly respond to, leaving Gabriel in the home with his abusers. Gabriel's mother and boyfriend were convicted of first-degree murder. In addition to the conviction of Gabriel's mother and her boyfriend, three DCFS employees are being criminally prosecuted stemming from Gabriel's death. In 2018, Anthony Avalos was also tortured and murdered by his mother and her boyfriend following 13 referrals to DCFS and countless red flags. Most recently, on July 5, 2019, 4 year-old Noah Cuatro died after multiple red flags of physical and sexual abuse that had been substantiated by DCFS. A social worker even filed a petition to remove Noah from his parents' home, which was granted. However, following the judge's granting of the petition of removal, no DCFS employee actually removed the child from the home for months, leaving him in what was known to be a dangerous home to die.

28. Following the death of Gabriel Fernandez and other child fatalities, the Los Angeles County Board of Supervisors created the Blue Ribbon on Child Protection and charged it with reviewing child protection failures. The Commission

published a report on April 18, 2014 date that stated, "The Commission unanimously concluded that a State of Emergency exists, which requires a fundamental transformation of the current child protection system." The Commission gave a plethora of recommendations to institute a complete systematic change to child protection services. Despite this, change did not come to the children that found themselves in the system.

29. Subsequent to the Blue Ribbon Commission Report there have been other child fatalities, including that of Anthony Avalos and Noah Cuatro, all from the same Lancaster DCFS office. After Anthony's death an audit was conducted of the handling of his case and child protection services in Los Angeles County. The 43-page audit report found systematic failures in how Anthony's case was handled and within DCFS. Among the action needed to work on these systematic failures was the training of social workers in various areas, including on how to interview children. DCFS employees have not been trained on how to effectively interview young children.

30. Anthony's death was not unexpected, neither was the abuse faced by his half siblings. DCFS records show that DCFS was complicit in the abuse and neglect of Anthony and his half siblings, and ultimately in Anthony's death. The records show that DCFS failed to properly investigate claims of physical and sexual abuse, including, but not limited to their interviews, failure to review DCFS history, failure to coordinate with law enforcement, violating their own policies, failing to complete Structured Decision Making Tool timely and truthfully, and failing to adjudicate despite the presence of exigency and imminent danger to Anthony and his half siblings. It should further be noted, that each referral led to a new social worker being assigned to the family and each failed in the duty of care owed to Anthony and his half siblings. In particular, there is a recording of a call reporting abuse where the social worker is actually laughing at the allegations of abuse. This

nonchalant attitude by the recipient of the report shows the complete disregard DCFS employees had for the safety of the children they were employed to protect. It further shows the lack of training and supervision that existed within an agency where an employee can laugh off a report alleging abuse of a child and consequently not accept it.

31. From 2013 to Anthony's death in 2018 there were at least 13 credible reports to DCFS from Anthony and his half siblings, family members, law enforcement, school administrators, a teacher, and a counselor who reported that Anthony and his six half siblings were denied food and water, beaten, sexually abused, dangled upside-down from a staircase, forced to crouch for hours while holding heavy objects, locked in small spaces with no access to the bathroom, forced to fight each other, and forced to eat from the trash. Despite these continued allegations of abuse, and some being found substantiated, DCFS continued to leave the children in Barron's and Leiva's care, exposing Anthony and his half siblings to continued torture and abuse. Below is a timeline of the all the referrals made to DCFS and details of each:

Timeline of Referrals of Abuse

a. February 28, 2013 and March 4, 2013

February 28, 2013 and then March 4, 2013, it was reported that Anthony's maternal step-grandfather had sexually abused him. The adequate allegation was substantiated, yet Anthony was never provided counseling or therapy to cope with the trauma and Barron was not disciplined for failing to safeguard Anthony.

Barron admitted to the DCFS social worker that Anthony had been acting strangely for months, including urinating on his younger sister. For months Barron observed Anthony's odd behavior and did not question it – allowing the sexual predator continuous access to him, despite his documented sexual predator history.

Barron failed to act and protect Anthony. However, despite this, DCFS failed to add an allegation of general neglect (WIC 300b) against Barron and failed to investigate her failure to protect Anthony and his half siblings despite overwhelming evidence that Barron was committing ongoing child abuse by not protecting Anthony from further sexual abuse. Furthermore, there was no safety plan put in place to ensure the children's safety and the supervision of the children to prevent sibling-to-sibling abuse. DCFS failed to provide counseling for Anthony for the sexual abuse and to Barron to teach her coping mechanisms for the strange behavior Anthony was exhibiting. Furthermore, DCFS failed to review Barron's history, which would have shown her own reports of physical abuse against her stepfather while a minor, the same stepdad who anally penetrated Anthony. The fact that Barron was also abused by her stepfather but had no problem with exposing her children to him and allowing her children to spend weekends alone with the sexual predator grandfather underscores her maligned parenting skills and her patent willful disregard for the safety or well-being of her children. Despite this clear need for intervention, DCFS did nothing.

b. April 29, 2014

Allegations were reported against Barron of physical and emotional abuse and neglect as it pertains to Anthony and three of his half siblings. The reports of general neglect were substantiated while allegations of physical abuse were wrongfully found to be inconclusive and emotional abuse unfounded.

The report entailed Barron hitting the children with objects, such as hoses, yelling at them, and locking them in their room for hours. When the social worker visited the home, Anthony and one of his half siblings disclosed that Barron hit them hard with belts.

During the social worker's visit regarding this referral, Barron admitted to

spanking the children. The social worker did not pose any follow up questions. She should have asked Barron if she left marks or bruises on the kids when she spanked them and whether she used any other objects to inflict corporal punishment. Barron also admitted that following the 2013 sexual abuse of Anthony by his step-grandfather, the Special Victim's Unit referred them to counseling, but she stopped attending because the therapist was more interested in her than Anthony. Again, the social worker did not conduct follow up questions to see what Barron meant by this.

The social worker failed to properly investigate the allegations of abuse and neglect reported by the caller and by the children. She took Barron's comments at face value and conducted no follow-up inquiry. The social worker ignored red flags that showed Barron was not capable of protecting or caring for her children – 1) corporal punishment she inflicted (as reported by relatives and the children), and 2) that a therapist was questioning her actions so Barron stopped taking Anthony to his much needed therapy sessions. On many occasions, DCFS should have "permanently" removed Anthony and his half-siblings from the home.

This referral led to the disclosure that Anthony was touching his sister's private parts, something Barron was already aware of and admitted to. Despite knowledge of this abuse, Barron continued to allow Anthony to share a room and bed with his sister and other half siblings and did not supervise them. DCFS employees knew this and did nothing. A safety plan was created to protect the children. It required that Anthony not sleep in the same room as his half-siblings and that he not be left alone with them. It was decided that Anthony would stay with his aunt Maria Barron until it was safe for him to return. During visits by a second social worker on May 9, 2014 and May 21, 2014, sleeping arrangements were not discussed, and the children were not interviewed in violation of multiple mandatory duty requirements. There is no note in the documents as to what was considered when deciding to return Anthony to the home. DCFS should have never returned

Anthony to the home. However, there was no change in sleeping arrangement as required by the safety plan and no further inquiry into this.

These allegations led to a Voluntary Maintenance Plan to be opened from May 20, 2014 to December 4, 2014 that required DCFS to monitor the family more closely and provide resources and services.

On June 18, 2014 and July 28, 2014, social worker Millman who was the assigned voluntary family maintenance social worker designated to work with the family visited the home. He failed to interview the children, despite having access, in violation of Department of Social Services mandatory duty requirements.

c. October 9, 2014

Allegations of physical and emotional abuse and neglect were made against Barron pertaining to Anthony and five of his half siblings. The allegation of general neglect was substantiated while the emotional abuse allegation regarding Anthony and the emotional abuse allegation pertaining to the half siblings was wrongfully inconclusive. The physical abuse allegations were deemed wrongfully inconclusive as to Anthony and unfounded as to his five half siblings.

The reporting parties, which included service providers that were mandated reporters, indicated that Barron "curses a great deal and should try to use kinder forms of communication with her children." Among the statements heard by the reporting party were, "He's a little shit, he's a little punk," "Shut up or I'll have to put your ass on timeout," and "Shut up Marie, you're faking it, you're making yourself cry. I don't even feel pity for you, you're annoying. The reporting party went so far as to tell DCFS that Barron had "nothing but anger toward the children," and that Barron had no affection towards the children and was "completely detached," inflicting a lot of verbal and emotional abuse against the children.

Two social workers visited the family on October 9, 2014. One was the social

worker that was given the referral and the other was Millman, who was the voluntary family maintenance social worker for the family. Both knew of the allegations of neglect and physical and emotional abuse and willfully failed to protect Anthony and his half-siblings by permanently removing them from the home.

Millman did not assess the family for emotional abuse, which includes cursing at a child or calling them a bad word as Barron did. Millman was complicit in the ongoing emotional abuse of Anthony and his half siblings by knowingly allowing the verbal abuse to continue and failing to report it. Furthermore, he failed to ensure the safety of the children when he had reports of abuse from mandated reporters. Millman's inaction and failure to intervene, sent the message to the children that they could not trust social workers to protect them, giving the children no hope that the torture and abuse they were suffering could be stopped by anyone.

When the second social worker arrived, Barron was resistant to let the children be interviewed and refused to do so. Instead of forcing Barron to allow her access to the children, the social worker went along with Barron and allowed Barron to call the shots as to how the investigation into the allegations of abuse would be investigated. Instead of demanding access to the children, the social worker scheduled a planned visit with Barron, giving her time to potentially intimidate and coach the children. This violated proper DSS mandatory duty requirements since the visit should have been unannounced.

The social worker returned on the next day. When speaking to Barron, the mother admitted to cussing at her children, hitting them with a belt, spanking her children, and putting hot sauce in their mouth if they talk back or say a bad word (which undoubtedly they learned from her given the numerous reports of her swearing at the children). DCFS social workers should have permanently removed all the children after this chocking physical abuse witnessed by social workers.

Rather than being appalled by this or finding that Barron had abused the children, the social worker advised Barron that if her actions caused marks or bruises on the children it would be inappropriate. In fact, leaving a mark or bruise on a child is illegal not just inappropriate. This is just another example of the complete incompetence and deliberate indifference that the social workers exhibited toward the children.

Barron refused to allow the children to be interviewed unless she was allowed in each interview. Again, the social worker acquiesced this demand, allowing Barron to direct the way the investigation into this referral was conducted, in violation of DSS mandatory duty requirements. The social worker acted in violation of DCFS policy and ignored the parental influence on a child's interview, especially when abuse is involved. Child R.O. reported that his mother spanked him and put hot sauce in his mouth, however, when the social worker asked if he was scared of Barron (in her presence), he stated no. What can be expected of a child that has already been abused and ignored by DCFS? Moreover, it is foolish to think any victim of abuse, particularly a young child, will admit to being scared of the alleged abuser, when the abuser is their mother and the child is in the mother's presence. In Anthony's interview, the social worker only asked about the sexual abuse by his step-grandfather, which Barron did not allow him to respond to. The social worker's failure to competently interview Anthony and to allow Barron's influence and interruption are a clear example of the social worker's deliberate indifference toward the children.

Following her interview of the children, on October 14, 2014, the social worker finally spoke with the reporting party who stated that she called the hotline to report the abuse because when she contacted social worker Millman, he "seemed to blow it all off like there was not a problem and that he had not even had the mother taking parenting class or anything." The reporting party stressed her

concerns for the children's safety. Instead of taking the report from a mandated reporter seriously, the social worker then called Millman who said he had no concerns for the children and that even though Barron did "cuss and yell" at the children that was just because she was overwhelmed by having so many children under the age of seven and that Barron was doing the best she could. It is egregious that Millman would minimize Barron's conduct and make excuses for her when even he had seen the verbal/emotional abuse. Millman's standard of Barron doing "the best she could" is not the standard to be used by DCFS and does not protect children. Ultimately the deliberate indifference of Millman and other social workers resulted in Barron continuing to the "the best she could" by torturing and killing Anthony.

d. November 5, 2014

A reporting party, designated as being a mandated reporter on the referral form, alleged a child in the home was the victim of abuse and that the siblings were at risk. DCFS wrongfully deemed this report "no disposition" for the allegations in this referral, which indicates that the referral was evaluated out or downgraded despite it being an immediate response.

The mandated reporter stated that while visiting the home, she heard one of the children say, "She's bad because she whips our ass." The reporter further stated that Barron "continues to get frustrated easily and hits the children as a form of discipline." Barron even threated the children in front of the reporter saying, "Don't think, because she is here, I won't whip your ass."

There was no disposition for the allegations in this referral, which indicates that the referral was evaluated out or downgraded despite it being an immediate response. DCFS again failed to follow their own policies in regards to investigation.

The mandated reporter stated that while visiting the home, she heard one of the children say, "She's bad because she whips our ass." The reporter further stated

that Barron "continues to get frustrated easily and hits the children as a form of discipline." Barron even threated the children in front of the reporter saying, "Don't think, because she is here, I won't whip your ass."

Here, DCFS again deliberately ignored red flags and signs of child abuse. A mandated reporter alleged Barron was being abusive to the children and DCFS chose not to investigate, in violation of mandatory duty requirements. DCFS's decision to do nothing, not even investigate the allegations of child abuse and the threat by Barron to whip her child shows a willful disregard for the children's well-being and safety. Even a few days letter when a DCFS learned that Barron failed to make the children available for any of their scheduled therapy sessions, DCFS chose to do nothing which facilitated Barron and Leiva's ongoing pattern of abuse, torture, and death.

e. April 24, 2015

A member of law enforcement reported to DCFS that allegations of physical abuse and that the siblings were at risk against Barron. The allegations were wrongfully deemed unfounded and inconclusive.

A.G. was taken to the police station after observing the child had injuries on his body when he picked him up for his weekly visit – an old bruise, a visible red hue to the back of the ear, and slight abrasion to the back of the neck. When Carlos Garcia, A.G.'s father asked what happened, A.G. said, "mom did this to me." When law enforcement tried to ask further questions, A.G. shut down. This was another red flag for DCFS as shutting down when asked of abuse is likely the result of intimidation, threats, and fear.

Social worker Anna Sciortino visited Barron's home in response to the referral. When she arrived, Barron was waiting on the porch. Barron refused to allow the social worker to enter the home and refused to allow the children to be interviewed. Furthermore, Barron knew the social worker would be coming and was

prepared with what she alleged was a note from A.G.'s daycare provider regarding A.G.'s injuries. The social worker did not insist and left the home. Again, here is another social worker that allows Barron to dictate how the investigation will be conducted in deliberate disregard for the well being of the children.

The referral was an "Immediate Response" referral that required the social worker see and speak to all the children. Despite this, the social worker left without doing either, in direct violation of DSS mandatory duty requirements. The social worker should have been on high alert given the urgency of the referral, Barron's refusal to let her in the home or speak to the children, and Barron being prepared with an alleged note from the daycare provider regarding A.G.'s injuries. These constitute more red flags about Barron and her abuse of the children that DCFS deliberately ignored. At this time, the social worker should have obtained a warrant to secure seeing the children immediately. However, instead of following DSS and DCFS policy and ensuring the immediate safety of the children, the social worker called Barron and scheduled a visit for April 27, three days after the date of an "Immediate Response" referral that required immediate action. Again, Barron is dictating how DCFS conducts its investigations, allowing her to coach the children prior to DCFS's scheduled visit. DCFS was aiding and abetting Barron in the ongoing child abuse and ordained her a social worker by allowing Barron to define the parameters of DCFS investigations.

Furthermore, the social worker was also negligent in her initial response to the referral by arriving alone to the Barron home. An "Immediate Response" referral requires the social worker to take law enforcement with them to conduct the investigation. This referral demonstrates the deliberate indifference of yet another DCFS social worker that failed to protect the children from Barron and continued to expose them to her abuse.

Social worker Sciortino made her announced and scheduled home visit on April 27, 2015. Sciortino informed Barron that she would need to conduct a criminal background check for every adult living in the home, this was to include Kareem Leiva. However, Barron said Leiva did not live at the home and Sciortino erroneously made no further inquiry. Sciortino should have known Barron was lying given that Anthony had disclosed to her that Leiva lived at the home, and the fact that Barron and Leiva had a child together in the home.

Sciortino then offered Barron services which Barron declined citing that the children still received therapy twice a week from the voluntary family maintenance case. This was false since the VFM case and associated services are reported in DCFS records to have stopped on December 4, 2014. However, despite this being documented, Sciortino was so grossly neglectful that she believed Barron and made no further inquiry or follow-up.

Sciortino interviewed A.G. during her April 27 visit. When she interviewed A.G., she observed the injuries that made up the allegations of physical abuse against Barron and asked A.G. how he got his "oweies." A.G. replied, "Daddy hurt me." A.G.'s disclosure of abuse to Sciortinio should have been grounds alone for permanent removal of the child, yet another example of a DCFS social worker's deliberate indifference. A.G. contradicted his initial disclosure regarding the abuse where he stated that Barron had caused the injuries. It should be noted that Sciortino conducted the interview in front of Barron, who was able to intimidate and scare A.G. into changing his initial disclosure. Barron's presence during the interview violated DCFS policies.

DCFS records show that Sciortino made no face-to-face visits in May. This is in violation of DCFS policies that require children in an open DCFS case to be seen face-to-face at a minimum once a month. Sciortino prepared the Structured Decision Making Assessment ("SDM") on June 4, 2015 having only visited the family in

April 2015, which is out of compliance with DCFS policy. In the SDM, Sciortino inaccurately scored the family on questions, even shockingly and falsely reporting that Barron had "strong skills" when it came to parenting. It was deliberate indifference of Sciortino to report Barron had a strong parenting skills given the number of allegations of neglect and physical and emotional abuse against her. Sciortino's inaccurate reporting on the SDM led to the closure of the referral/investigation and DCFS's failure to investigate.

f. April 27, 2015

Barron made allegations of emotional abuse and general neglect against A.G.'s father following an altercation when they were exchanging A.G. in which Garcia threw a show at Barron and the children witnessed it. Only an allegation of general neglect was found substantiated.

The documentation for the referral shows no investigation being conducted by Bulkley, or the April 24 referral social worker, Sciortino. While there is no documentation of Bulkley conducting an investigation, he prepared the referral's disposition, erroneously recommending the referral be closed although the risk assessments on the "Screener's Narrative" shows that her family is at a "HIGH risk of abuse or neglect," based on 1) the number of children involved, 2) the current allegations, 3) the number of previous referrals/cases, and 4) the mother's past criminal history. It is shocking and aghast to see a social worker show deliberate indifference by closing a case when the family is assessed as being at a high risk of abuse or neglect. This evil conduct was nothing short of criminal and willful disregard. All the children should have been removed from the home.

DCFS's conduct in reference to this referral shows multiple levels of negligence and deliberate indifference. First, Bulkley relied on "the children are currently involved in a VFM case and getting services." This is inaccurate as the voluntary family maintenance case with social worker Millman was from May 20,

2014 to December 2, 2014. There was no VFM case at the time of this referral, and none had existed for more than four months. Next, Bulkley deems the allegations inconclusive because the children are already in an open case, but there was no evidence of an open case. Then, like Millman, Bulkley makes excuses for Barron stating that she has her hands full with five children under the age of seven. If this is the standard for effective parenting endorsed by DCFS social workers, more children will end up dead in the coming years.

g. June 12, 2015

There was an "Immediate Response" referral with allegations of physical abuse against Barron as a result of her bringing A.G. to the Lancaster DCFS office for a visit with Garcia with a visible bruise to his forehead, a scrape to his chin, and a bruise to his upper forearm. Barron claimed A.G. received the injuries from falling in the shower. The allegations in this referral were all wrongfully deemed to be unfounded.

A social worker was the reporting party in this referral after observing that A.G. had a visible bruise to his forehead, a scrape on his chin, and a bruise to his upper forearm. At the time this referral was made, there were already seven prior referrals and an open referral from April 24, 2015, more than enough to have all the children permanently removed from the home.

Sciortino was given this referral. Barron stated that A.G. had fallen in the shower. When Sciortino interviewed A.G. on June 12 about his injuries, the child stated that A.G. had not been with him in a week making it impossible that the injuries were from falling in the shower at his house. Sciortino confirmed that she was aware A.G. had not been in Garcia's home in a week. However, there is no evidence that she made a further inquiry with Barron despite her categorical lie to DCFS.

Sciortino ordered a forensic exam of A.G., but a HUB employee stated the doctor said there was no need for a forensic exam. It was negligent and deliberate willful disregard that Sciortino did not talk to the doctor personally to share her additional knowledge of the case. Best practice would have been to speak with the doctor and convey the differing injuries of the injury because her telling of the events would have influenced the doctor's decision that the injuries could have occurred or could not have occurred as stated by Barron.

h. <u>September 18, 2015</u>

First Referral

There was a referral with allegations of physical child abuse against Barron. The reporting party was an employee at Lincoln Elementary School to whom Anthony confided in. Anthony told the reporting party that he moved to his aunt's home because his mom was hitting him and his siblings, locking them in their room for hours as punishment, would have Anthony and in his siblings do the "Captain's Chair" which consisted of squatting against the wall for long periods of time, and hit them with a ping pong paddle in the mouth, butt, and hands. These allegations were all shockingly and wrongfully deemed inconclusive.

An employee at Lincoln Elementary School to whom Anthony confided in reported that Anthony told the reporting party that he moved to his aunt's home because his mom was hitting him and his siblings, locking them in their room for hours as punishment, would have Anthony and in his siblings do the "Captain's Chair" which consisted of squatting against the wall for long periods of time, and hit them with a ping pong paddle in the mouth, butt, and hands. Despite this report being made on September 18, social worker Ikea Vernon did not make initial contact with the family until September 21, in violation of DSS mandatory duty requirements.

During Vernon's face to face visit with Barron, the children's uncle David

Barron and aunt Maria Barron, the mother Barron reported that the children had been with her brother's family since September 17 because the children disclosed to David abuse by Leiva and law enforcement said for the children to stay with David. Interestingly enough, despite the countless allegations of child abuse made against Barron and Leiva prior to this referral, not once had DCFS removed the children from the home. It had to be a relative to step in and try to stop the children's exposure to the abuse.

Furthermore, despite this referral relating to allegations of physical abuse and general neglect, there is no documentation that Vernon created a safety plan for the children to remain with the aunt and uncle while the investigation was ongoing. In fact, there is no mention of a safety plan or course of action throughout the investigation, in violation of DD mandatory reporting requirements.

When David and Maria Barron, the children's aunt and uncle went to the Lancaster DCFS office and asked Vernon about the status of the investigation, Vernon refused to give them any information and told them the investigation was confidential and they would need to get information from Barron, the accused abuser. Vernon failed to engage the aunt and uncle who were helping to keep the children safe while she conducted her investigation, and incorrectly told them she could not advise them as to the status of the investigation. Vernon and other social workers had a pattern of siding with Barron in these referrals, making excuses for her and failing to implement DCFS policies for the safety of the children, and disregarding the individuals like David and Maria that were actively trying to protect the children from further abuse.

Vernon's Interview with Barron

Regarding the allegations of abuse, Barron told Vernon, "I always asked them [the children] if they felt like they are being hurt by Kareem and they would say, 'No.'" This is not a typical question for a parent to ask their children unless there is

a suspicion of mistreatment, and social worker Vernon did not pick up on this red flag, and consequently making no further investigation. Despite the children making allegations of abuse against Leiva, Vernon made no contact with him and took Barron's denial of abuse as truth.

There were also allegations of general neglect surrounding the children being locked in their bedrooms, their basic needs not being met, and Barron's mental health. While Barron told Vernon she never locks the children in their room, Vernon did observe that the door to the children's room had a lock on the outside of the door. Despite seeing this, Vernon failed to question this, did not document if she looked inside the room to see if that side had a lock, and did not question Barron about the safety concerns associated with having a lock on the outside of the door.

Vernon's Interview with David Barron

David Barron reported that Barron's children told him and his wife Maria that Barron will lock them in their rooms for hours at a time, where they urinate and defecate on themselves and the floor. Standing alone, this willful neglect report was enough to remove all the children from the house of horrors.

In regards to the children's allegations of food deprivation, David stated that the children said they are not given food and that one sibling is forced to eat partially frozen burritos. The child himself also reported this to Vernon. David further stated that he helps Barron by giving her food sometimes for the children. Vernon made no further inquiry into how often David gave the family food or why this was necessary.

David also reported to DCFS that sometimes the children do not bathe for weeks and that they have arrived at his home with dried feces in their pants. Vernon failed to ask any follow-up questions.

David further reported to Vernon that in the past, he and his wife had to raise Anthony and his half siblings because Barron was partying, using

methamphetamine, and saying she was suicidal. Despite these serious allegations of potential mental instability, Vernon failed to address this topic further with David and Barron, and failed to drug test Barron. This exemplifies the gross incompetence and deliberate indifference of DCFS and this social worker. Allegations that a mother is on drugs and suicidal directly effect the safety of the children in the home and should have been immediately addressed by Vernon, instead the allegations were not addressed at all.

Children's Reports of Abuse and Neglect to Social Worker Vernon While Staying with David and Maria Barron

When interviewing the children, Vernon minimizes and discounts their disclosures of abuse. When one of Anthony's younger brothers reported, "Kareem slams me on (redacted)." While Vernon observed this child had a small bruise on his right cheek her report states that she could not be sure the bruise was caused by abuse and that she did not get a meaningful statement from this child. Apparently reports of physical abuse do not equate to meaningful statements. This child also reported not bathing regularly, which Vernon did not inquire about, in violation of DSS mandatory duty requirements.

Another of Anthony's brothers disclosed, "Kareem hits me, Anthony," and other siblings. Further reporting, "Kareem hung me upside down on the floor and hit my head." He said, "My mom spanks me on the butt with a belt." He said, "Kareem spanks me everywhere, he puts me in my room and makes me be on trouble; he hurts me on my head, cheek, and butt." These shocking disclosures alone should have warranted permanent removal of all of the children.

Anthony's younger sister reported, "Kareem hits (redacted) and bangs his head on the wall." She further reported, "Kareem wil place (redacted) arms across his chest and try to choke him," and that Leiva hangs one of her brothers over the stairs by his legs, gives her and another siblings "Indian burns," and that Leiva will

kick one of the brothers in the leg really hard. This child told Vernon that she wanted to live with her aunt and uncle because her mother Barron, "Hits us," and had hit her on the, "butt with a belt, her hand, or hard sandals or shoes." This little girl then showed Vernon a small mark on her right calf stating that it was from one Halloween when Barron was curling her hair and, "burned her with the curling iron, because 'I kept moving and she said stop." In her report, Vernon minimizes this injury saying it had healed and was very small. Vernon made no further inquiry into the allegations of abuse or the child's desire to live with her aunt and uncle. This child also disclosed that Barron locks them in their room, locking the door from the outside. She also reported not being given food and getting in trouble when she tried to sneak food because she was hungry by being forced to "scrub the walls until the night time."

Anthony reported when he was with his uncle and aunt, "I'm never ever going to see Heather again, she locks us up in our rooms and makes us starving." He then stated Barron, "switches the locks and the lock is on the outside of my room." At least two of his half siblings confirmed this and a service provider confirmed seeing a lock on the boys' door. Anthony further reported "We don't have enough food sometimes or he [Leiva] doesn't let me eat." Anthony further reported that he "is not able to bathe all the time." Vernon made no further inquiry. When a sibling of Anthony reported that he was only able to take cold baths, Vernon also made no further inquiry. Vernon's failures to investigate exhibits the highest level of willful disregard and deliberate indifference toward those helpless children and borders on criminal.

Vernon's Failure to Assess if there were Signs of Abuse

At no time in her report, did Vernon describe what clothing the children were wearing, only stating they were "appropriately dressed." This raises the question of how much of the children's bodies were exposed for Vernon to be able to assess

whether there were injuries and signs of abuse. The LA County DCFS Child Welfare Policy Manual requires that when conducting a visual exam of a child for suspected injuries, the social worker must determine If there is cause to believe that physical harm has occurred based on the nature of the allegation, the age of the child, and the results of her interview with the child and/or parent/guardian. Here, the referral was for physical abuse, the interviews of David and Maria, and all the children gave cause to believe physical harm had occurred while in Barron's home. However, Vernon did not arrange the children's clothes and did not request a Public Health Nurse to assess the children for signs of abuse as required due to Anthony and his brothers being of the opposite sex and above the age of three.

Given the significant disclosures of abuse by Anthony and his siblings, the best practice would have been to have the children forensically interviewed and forensically examined by a Forensic Pediatrician. Vernon failed to do both.

Vernon's Interview with Social Worker Wasse

At the time of this referral, there was an open family maintenance case for one of Anthony's brothers and social worker Mishi Wasse was the assigned social worker. DCFS failed the children by customarily assigning different social workers for each new allegation of abuse! Wasse told Vernon she had no concerns for the children in Barron's home. However, she then relays disclosures of abuse made by Anthony's brother against Leiva – that Leiva farts in his face, slams him against the wall, and hits his head on the wall. Wasse's incompetence and deliberate indifference is shown by her not deeming these serious reports of abuse as being "of concern." Furthermore, Wasse and Vernon show complete incompetence and willful disregard as neither one created a new referral for these allegations of physical absue and as such no investigation was conducted.

Vernon's Interview with Service Providers

Vernon failed to inquire about the frequency of their contact with the

family and obtain dates of their home visits. When the service providers said they were working with Barron on how she disciplined the children, Vernon made no further inquiry as to why the service providers felt this was needed or how Barron disciplined the children.

Interaction between Social Worker Vernon While Staying with Mother Heather Barron

On September 25, 2015, Barron called Vernon because the children's school would not release the children to her since school personnel had spoken with David and Maria Barron. Vernon, instead of being concerned for the well-being of the children, went to the school to see why the children were being withheld from Barron. Despite there allegedly being a verbal agreement that the children would remain with the aunt and uncle until September 25, Barron said she got the children on September 24. Vernon had no idea. Furthermore, there is no documentation that the return of the children to Barron had been discussed or safety measures put in place and she had no contact with the second alleged abuser, Leiva, prior to Barron taking the children. Vernon re-interviewed the children.

Vernon's Visit Following the Children's Return to Barron's Home

The children returned to Barron's home on September 24, 2015, Vernon did not visit the children at the home to ensure their safety until October 29, 2015. She then returned on November 20, but left when she received a work call and did not return until November 23. Again, no meaningful investigation occurred on theses visits, in direct violation of mandatory.

Even when Vernon was informed on October 5, 2015 that Anthony had a fractured foot and that Barron did not plan to take him to the hospital because Barron said it was "not bad and was not broken" Vernon made no visit, no investigation on how Anthony fractured his leg, or created a new referral for potential physical abuse. Vernon did tell Barron to take Anthony to the hospital and

provide her with a copy of the after visit summary, however, Barron did not provided this documentation and Vernon conducted no follow-up to ensure Anthony had been seen by a doctor.

Vernon's Preparation of Documents Late

Vernon created the initial Safety Assessment on November 17, 2015, when pursuant to DSS policy, it should have been created on September 22, 2015. Furthermore, Vernon reported on the assessment that the children were safe despite all the reports of abuse she received directly from the children, underscoring her deliberate indifference toward the children.

The SDM Risk Assessment was also prepared late with Vernon creating it on December 8, 2015 when DCFS guidelines required it to be prepared on November 23, 2015.

Vernon's Choice to Protect the Mother Instead of the Children

According to the risk assessment, the final risk level of abuse and neglect was high, and the recommended decision was to promote the referral to a case. However, Vernon did not follow the recommendation writing, "Mother demonstrates a protective capacity over the children and provides for their basic needs. SW did not observe marks or bruises indicative of abuse or neglect and children recanted their statements reporting that they were coached by the maternal uncle and aunt."

Vernon's decision to protect Barron by siding with her shows her complete lack of training, inability to property assess a situation, failure to conduct a proper investigation, and so many acts of gross negligence and deliberate disregard toward the children. Vernon should have had a forensic interview conducted of each of the children, but did no further investigation – believing the mother's denials of abuse and the convenient excuse that the aunt and uncle who were trying to help coached the children.

Second Referral

Deputy Gelado of the Lancaster Sheriff's Station called in allegations of physical abuse and neglect against Barron and Leiva. This referral was opened at the same time as the first, but was assigned to social worker Gabriela Robles. Deputy Gelado reported to DCFS that after interviewing the children, law enforcement decided to have them stay with the aunt, and the mother agreed. Deputy Gelado relayed to DCFS all the acts of abuse the children disclosed to law enforcement, which were consistent with the reports of abuse later made by the children to social worker Vernon.

Social worker Robles did not follow DSS and DCFS policies and attempted contact on two occasions by herself. Ultimately, she never spoke with anyone involved in this referral. She failed to review her assigned referral (going to Barron's house instead of David and Maria's). Deputy Gelado's allegations were wrongfully deemed unfounded.

i. <u>September 19, 2015</u>

Reporting party alleged physical abuse and that the siblings were at risk of abuse against Leiva because he was a member of the MS-13 gang and had been abusing Anthony and his half-brothers. DCFS wrongfully made no disposition.

An uncle of Anthony and his half siblings made reports of abuse consisted with the report the children had made to social worker Vernon on September 21, 2015 as well as adding new allegations – Leiva slammed the boys on the floor, kicked Anthony in the stomach, threw dirty diapers at the children, locked them in their bedrooms, and doesn't give them food. The uncle further reported that Barron cut her wrists five days prior and sent him pictures of it saying she hates her life and wants to die.

Despite all these significant reports that placed the children's safety and well-being into question, DCFS exhibited willful disregard by choosing to incorrectly

evaluate the referral out. This means that there was no investigation into this report of abuse or of Barron trying to commit suicide. DCFS's own policy required this referral be treated as a new referral and be investigated as such.

DCFS failed to follow their own policies and left the children in a dangerous environment when they should have all been permanently removed from the home.

j. April 28, 2016

An Immediate Response referral was created alleging general neglect against Barron and physical abuse, emotional abuse, and sibling at risk against Leiva when all the children were observed with bruises on their faces. The allegation against Barron was shockingly and wrongfully deemed unfounded and the rest inconclusive.

The referral included reports that Leiva made the children fight each other, children are placed in time out for very long period of time, food is withheld, children dig food out of the trash, and that Leiva mistreats all the children but his biological ones.

The first social worker assigned could not make contact with the family. The second social worker was Michelle Thomas who went to Barron's home on April 29 without law enforcement in violation of DCFS policy.

Thomas believed Barron's report that she had not seen Leiva since January. When asked about her mental health, Barron denies that she is suicidal, but does state she does not attend therapy. Thomas did not check the mother's wrist for evidence of the alleged cutting and did not make her submit to a drug test.

When interviewing the children, Thomas used a template as shown in the verbal child interviews all reading the same. The children, not surprisingly, all denied that there was any abuse or neglect in the home. Anthony even went so far as to deny ever knowing Leiva. This should have raised a huge red flag with Thomas that the kids were lying, had she reviewed their prior referrals, because in April 2015, Anthony reported that Leiva sometimes lived with them. It is obvious that

Anthony knows who Leiva is, but they have been intimidated, coached by Barron, and were in fear of further abuse. Moreover, one of Anthony's younger brother gave Thomas the same account as Barron about how they all received bruises on their faces – they were fighting each other. However, he also admitted that Leiva was present when the children were fighting which directly contradicts Barron's statement to Thomas that she had not seen Leiva since January. When Thomas checks in with family maintenance social worker Wasse about the family, Wasse tells Thomas that she believes Leiva is hanging around the house. Furthermore both Wasse and Vernon, the social worker that investigated the April 2015 referral, both told Thomas that the children knew who Leiva was. Despite the significant contradiction, Wasse's own belief that Leiva was present in the home, and Wasse's and Vernon's reports that the children knew who Leiva was, Thomas conducted no further inquiry into this or made any attempt to contact Leiva, in direct violation of DSS and DCFS guidelines and policies. In fact, Thomas recommended that the case be closed, despite the issues surrounding Leiva and the fact that the SDM Risk Assessment indicated the children were at "high risk for abuse and neglect in the home with a recommendation to promote."

k. November 2017

Another report of abuse was filed in November 2017 and wrongfully deemed inconclusive.

l. June 20, 2018

Anthony and his half-siblings were was tortured and abused for years as evidenced by the above referrals. The torture and abuse escalated in the days prior to his death, presumably because he said he liked boys. Anthony had hot sauce poured on his face and mouth, was whipped with a looped cord belt, held upside down and dropped on his head repeatedly, withheld food and then force fed, slammed into furniture and the floor, denied access to the bathroom, and made to endure his

siblings inflicting pain on him pursuant to the demands of Barron and Leiva. "At one point, Anthony could not walk, was unconscious lying on his bedroom floor for hours, was not provided medical attention and could not eat on his own."

Anthony's injuries included sunken eyes and cardiac arrest. Medical findings related to his death included bruising, ulcerations, a brain hemorrhage, multiple hematomas, cerebral edema, scattered subarachnoid bleeding/possible venous sinus thrombosis, severe hyperkalemia, hypernatremia, acute kidney injury, and multiple other abrasions.

FIRST CAUSE OF ACTION

WRONGFUL DEATH

[California Code of Civil Procedure Section 377.60]

(By Victor Avalos against All Defendants)

32. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

33. Plaintiff Victor Avalos as surviving heir of his son Anthony Avalos asserts a wrongful death action against all Defendants pursuant to §377.60 et seq. of the California Code of Civil Procedure. Said claim is based upon the fact that the negligent, reckless, and wrongful acts and omissions of Defendants, as alleged herein, was a direct and legal cause of Anthony's death.

34. Anthony's death was not unexpected. The DCFS records show that DCFS was complicit in the abuse and neglect of Anthony and his half siblings, and ultimately in Anthony's death. The records show that DCFS failed to investigate properly, including, but not limited to their interviews, failure to review DCFS history, failure to coordinate with law enforcement, violating their own policies failing to complete Structured Decision Making Tool timely and truthfully, and

failing to adjudicate despite the presence of exigency and imminent danger to Anthony and his half siblings. It should further be noted, that each referral led to a new social worker being assigned to the family and each failed in the duty of care owed to Anthony and his half siblings.

35. Hathaway failed to report suspected child abuse as evidenced by Dixon's testimony at the preliminary hearing in the Gabriel Fernandez case. Furthermore, Hathaway's actions in the Fernandez case and its aftermath placed Anthony directly in harm's way. Hathaway continued to use Dixon and assigned her to be Anthony's therapist. Hathaway should have immediately removed Dixon following her preliminary hearing testimony and conducted an audit of all the cases she had been assigned to in order to see if there were other occasions where she failed to report suspected child abuse.

36. As a result of the above acts and omissions of Defendants, Anthony was tortured and abused for years, as evidenced by the above referrals. The torture and abuse escalated in the days prior to his death, presumably because he said he liked boys. Anthony had hot sauce poured on his face and mouth, was whipped with a looped cord belt, held upside down and dropped on his head repeatedly, withheld food and then force fed, slammed into furniture and the floor, denied access to the bathroom, and made to endure his siblings inflicting pain on him pursuant to the demands of Barron and Leiva.

37. Anthony's injuries included sunken eyes and cardiac arrest. Medical findings related to his death included bruising, ulcerations, a brain hemorrhage, multiple hematomas, cerebral edema, scattered subarachnoid bleeding/possible venous sinus thrombosis, severe hyperkalemia, hypernatremia, acute kidney injury, and multiple other abrasions.

38. As a direct and proximate result of Defendants' conduct, as alleged above, Plaintiff Victor Avalos has been deprived of the life-long love, companionship,

comfort, society, and care of Anthony, and will be deprived for the remainder of his natural life.

39. Plaintiff Victor Avalos is claiming wrongful death damages under the Fourteenth Amendment claims, and also under their state law claims for negligence and civil rights violations.

SECOND CAUSE OF ACTION

WRONGFUL DEATH SOUNDING IN NEGLIGENCE

(By Victor Avalos against All Defendants)

40. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

41. Defendants had a legal duty to Plaintiffs. Defendants knew of the abuse and misconduct occurring in the Barron home, yet failed to take appropriate action to investigate and stop the abuse. Defendants received numerous reports and complaints about the Barron home and the suspected abuse of the minor Plaintiffs and decedent. However, Defendants failed to properly and/or adequately investigate the complaints and repeatedly failed to take appropriate action as mandated by the Welfare and Institutions Code sections and/or Department of Social Services ("DSS") regulations set forth below.

42. Defendants County and DOES 1-50, despite receiving numerous reports and evidence of abuse and neglect of minor Plaintiffs and decedent, negligently investigated these reports, failed to develop a mandatory "case plan", and failed to place a "300 hold" on the children, pursuant to Welfare and Institutions Code Section 300, et seq.

43. Defendants failed to investigate or otherwise respond to the reported instances of child abuse and/or neglect of minor Plaintiffs and decedent as mandated

by Welfare and Institutions Code Sections 328, 16504(a), 16501(d), and/or 16501(f), and/or DSS Regulations 31-101, 31-105, 31-110, 31-115, 31-120, and/or 31-125.

44. Welfare and Institutions Code Section 328 states, "The social worker shall interview any child four years of age or older who is the subject of an investigation to ascertain the child's view of the home environment. DCFS made visits to the Barron home in which social workers did not interview Anthony or his half-siblings that were four years and older.

45. Welfare and Institutions Code Section 16501(f) states, "County welfare departments shall respond to any report of imminent danger of a child immediately." There are countless instances of Anthony and his half-siblings being in imminent danger and there was no immediate response from social workers. Additionally, some referral were emergency referrals and social workers failed to see or speak to the children the day of the referral.

46. DSS Regulation 31-101 states DCFS workers need to be skilled in "emergency response". The social workers responding to the Barron home regarding referrals made about child abuse against Anthony and his half-siblings were not skilled in this area. There is evidence that even referrals designated emergency referrals were not properly responded to by social workers, and sometimes were not responded to at all.

47. DSS Regulation 31-105 states that a social worker shall immediately initiate and complete the Emergency Response Protocol process when it is necessary to determine whether an in-person investigation is required. Furthermore, the social worker shall record all available and appropriate information on the Emergency Response Protocol form SOC 423 (10/92), or an approved substitute. DCFS social workers repeatedly failed to fill out the requisite forms in the instant case, including, but not limited to, SOC 423 Form (10/92).

48. DSS Regulation 31-115 dictates that among the factors in determining the need for an in-person investigation, is when allegations and/or behavioral indicators which are suggestive of abuse, neglect, or exploitation. Here, DCFS social workers failed on multiple occasions to follow this, which amounts to statutory breach of a mandatory duty.

49. Defendants failed to accept reports of suspected child abuse and/or neglect of minor Plaintiffs and decedent without legal justification and did not properly maintain a record of all reports received as mandated by Penal Code section 11165.9. DCFS violated their statutory duty by refusing to accept a case of reported child abuse related to Anthony and his siblings on more than one occasion. DCFS's failure to take a report is even more egregious than the act itself of refusing to accept a report. There is a recording of a call reporting abuse where the social worker is actually laughing at the allegations of abuse. This nonchalant attitude by the recipient of the report shows the complete disregard DCFS employees had for the safety of the children they were employed to protect. It further shows the lack of training and supervision that existed within an agency where an employee can laugh off a report alleging abuse of a child and consequently not accept it.

50. As "mandated reporters" under Penal Code sections 11165.7(a)(15) and (18), Defendants failed to report suspected child abuse and/or neglect of minor Plaintiffs and decedent to appropriate authorities and failed to make initial reports or follow up reports within 36 hours of receiving said reports of abuse and/or neglect as mandated by Penal Code sections 11165.9 and 11166(a).

51. Defendant negligently delivered child protective services of minor Plaintiffs and decedent by failing to properly conduct an assessment and develop a case plan as mandated by DSS Regulations 31-201, 31-205, 31-206, and/or Welfare and Institutions Code section 16501.1(d).

52. Even though said Defendants received various reports of abuse and/or neglect of minor Plaintiffs and decedent, and observed some of the abuse and/or neglect themselves, Defendants failed to conduct a basic evaluation of risks to determine whether an emergency situation existed as mandated by Welfare and Institutions Code section 16504 and/or DSS Regulations at 31-101, 31-105, 31-110, 31-115, 31-120, and/or 31-128.

53. Despite Defendants receiving numerous reports of abuse and/or neglect of minor Plaintiffs and decedent from multiple sources, and observing some of the abuse and/or neglect themselves, Defendants failed to control the conduct of Heather Barron and Kareem Leiva, and/or otherwise protect minor Plaintiffs and decedent as mandated by Welfare and Institutions Code sections 16504(a), 16501(d), and/or 16501(f).

54. These negligent and reckless acts and omissions were a substantial factor and a legal cause of the damages and injuries sustained by minor Plaintiffs and decedent, and the legal cause of decedent's death as alleged in this complaint. Had Defendants fulfilled their mandated and legal duty of care, minor Plaintiffs and decedent would not have been harmed and decedent would not have been murdered.

55. Additionally, under California Evidence Code section 669, the negligence of Defendants, and their employees or agents, may be presumed for the reason that:

a. Defendants, and each of them, violated the child protection statutes, placing minor Plaintiffs and decedent in harms way pursuant to California Penal Code section 273(a) (Endangerment) and failing to investigate reports of child abuse;

b. The violations proximately caused injury to minor Plaintiffs and decedent;

c. The injuries to minor Plaintiffs and decedent were occurrences of the nature which the statutes are designed to prevent; and

d. Minor Plaintiffs and decedent were members of the class of persons for whose protection these statutes were adopted.

56. As a direct and proximate result of the acts and omissions of Defendants, including its employees or agents, and each of them, as alleged herein, minor Plaintiffs and decedent suffered injuries including, but not limited to, physical and mental pain and suffering, physical injuries, past and future costs in medical care and treatment, and past and future loss of earnings capacity, in an amount not yet ascertained, but which exceeds the minimum jurisdictional limits of the Court.

57. As a direct and proximate result of the act and omissions of Defendants, including its employees or agents, and each of them, as alleged herein, Avalos and minor Plaintiffs suffered the loss of companionship of Anthony Avalos.

THIRD CAUSE OF ACTION

WRONGFUL DEATH SOUNDING IN GROSS NEGLIGENCE

(By Victor Avalos against Hathaway)

58. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

59. As stated above, Defendant Hathaway acted negligently and with willful disregard towards Plaintiffs. It had a duty of care that it breached, which was the actual and proximate cause of Plaintiffs' injuries.

60. In doing each and all of the acts and omissions herein alleged, Hathaway engaged in a course of conduct which was grossly negligent, extreme and outrageous. Hathaway engaged in said course of conduct with wanton and reckless disregard of the consequences or harm that was likely to result to minor Plaintiffs and decedent.

61. Hathaway assigned employee Barbara Dixon to work with the Barron family after it had actual knowledge that, despite being a mandated reporter, Ms. Dixon had in the case of Gabriel Fernandez, another child who was killed while under DCFS' care, consciously, intentionally, and willfully not reported abuse of Fernandez by his mother and her boyfriend. Ms. Dixon is and was a mandated reporter under Penal Code section 11165.7(a)(15) and (18) that intentionally violated her duties under the code section to report child abuse, this is a crime.

62. Additionally, Hathaway has a policy of having supervisors discourage the reporting of child abuse in violation of mandated reporter laws. Ms. Dixon testified, after being granted immunity, under oath in the Gabriel Fernandez case, that she had been told by her supervisor not to make a report regarding the abuse of Gabriel Fernandez.

Q: So one of those requirements was that when you observed injuries, you were to call the DCFS hotline; is that correct?
A: I was to discuss it with my supervisor.
Q: You believed that your duties as a mandated reporter were to discuss it with your supervisor?
A: Correct.
Q: Not to call 911 or the DCFS hotline?
A: Correct.
Q: And was that your custom and practice while working at Hathaway Sycamore?
A: Yes.
Q: So whenever you observed injuries on a case that you - - whenever you observed injuries on a child abuse case you were servicing, you would first discuss with your supervisor whether this was something that needed to be reported to the DCFS hotline?
A: Correct.
Q: So if your supervisor said, 'Ms. Dixon, don't report these injuries to the hotline,' you follow that directive?
A: Correct.

63. Despite all this, Hathaway, continued to employ Ms. Dixon to work with children and assigned her to work with decedent, knowingly placing them in harm's

way. Hathaway's actions in the Fernandez case and its aftermath placed Anthony directly in harm's way. Defendant Hathaway should have immediately removed Ms. Dixon following her preliminary hearing testimony and conducted an audit of all the cases she had been assigned to in order to see if there were other occasions where she failed to report suspected child abuse.

64. The conduct of Defendant Hathaway was willful, malicious, conscious, extreme, outrageous, and warrants the imposition of punitive damages against it.

FOURTH CAUSE OF ACTION

WRONGFUL DEATH SOUNDING IN NEGLIGENT SUPERVISION

(By Victor Avalos against All Defendants)

65. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

66. At all times mentioned herein, Defendants were under a duty to supervise the conduct of its social workers and employees to enforce those regulations necessary for the proper enforcement of the laws of the State of California and to exercise ordinary care to protect minor Plaintiffs and decedent from abuse as established herein.

67. Defendants were negligence and careless in that they failed to properly train and supervise its employees. Furthermore, Defendants negligently entrusted its employees or agents with exercising the laws for the protection of minor Plaintiffs and decedent.

68. Defendants negligently failed to supervise their employees appropriately so as to prevent the type of violations of policy and statutory laws and regulations as alleged herein that led to the injuries sustained by minor Plaintiffs and the death of Anthony Avalos.

69. Defendants negligently failed to supervise their employees so as to prevent the types of incidents herein alleged, failing to properly train and to supervise the training of its employees or agents about correct manner in which to effectuate the child protection laws enacted to protect minor Plaintiffs and decedent.

FIFTH CAUSE OF ACTION

WRONGFUL DEATH SOUNDING IN NEGLIGENT HIRING AND RETENTION

(By Victor Avalos against All Defendants)

70. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

71. As agencies working with children, DCFS and Hathaway were entrusted with the care of minor children within their system.

72. At no time during the periods of time alleged did Defendants have in place a system or procedure to reasonably investigate, supervise, and monitor its employees.

73. At no time during the periods alleged did Defendant County have in place a system or procedure to reasonably investigate, monitor, or supervise Hathaway, one of its largest agents used to provide mental health services to children and their families within the DCFS system.

74. Defendants were or had reason to be aware of and understand how vulnerable children are to sexual and physical abuse.

75. Defendants were put on notice, and had reason to know that Hathaway employee Barbara Dixon and her supervisor, had previously engaged in dangerous and inappropriate conduct, and that it was, or should have been foreseeable, that they would engage in dangerous and inappropriate conduct again.

76. DCFS knew of the pattern of Hathaway to violate mandatory reporting laws. Dixon herself testified in a preliminary hearing in the Gabriel Fernandez case that she it was the custom and policy of Hathaway and herself not to report child abuse and in fact she did not report the abuse she observed of Gabriel Fernandez and was directed to do so by her supervisor. Despite knowing this, DCFS continued to contract with Hathaway, and even had Dixon assigned to Avalos and his family. To this day, DCFS continued to contract with Hathaway.

77. For its part, Hathaway hired Dixon as a licensed therapist once she received her licensed, post the death of Gabriel Fernandez, and retained her and her supervisor even after her testimony about not reporting child abuse.

78. Defendants' conduct was a breach of their duties to Avalos and his half-siblings.

SIXTH CAUSE OF ACTION

WRONGFUL DEATH SOUNDING IN VIOLATION OF CIVIL RIGHTS

[California Civil Code Sections 52.1]

(By Victor Avalos against County of Los Angeles)

79. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

80. This action is brought pursuant to California Civil Code Section 52.1. This cause of action is to redress the deprivation, under color of statute, ordinance, regulation, policy, custom, or practice of usage, of rights, privileges, and immunities secured by the Constitutions of the United States and California including, but not limited to, the right to be free from violence and threats of violence.

81. Plaintiffs are informed and believe, and thereon allege, that Defendants, and each of them, violated minor Plaintiffs and decedent's civil rights and subjected them to physical violence.

82. During all times mentioned herein, Defendants, separately and in concert, acted under color and pretense of law, under color of the statutes, ordinances, regulations, policies, practices, customs, and usages of the State of California and County of Los Angeles. Each of the Defendants, separately and in concert, deprived minor Plaintiffs and decedent of the rights and privileges secured to them by the Civil Code as alleged herein.

83. Minor Plaintiffs and decedent were subjected to the deprivations alleged herein as a result of the failure of Defendants to properly train their employees or agents.

84. As a direct and proximate result of the acts and omissions of Defendants, including its employees or agents, as alleged herein, minor Plaintiffs and decedent suffered injuries including, but not limited to physical and mental pain and suffering, physical injuries, past and future costs of medical care and treatment, and past and future loss of earnings and earnings capacity, in an amount not yet ascertained, but which exceeds the minimum jurisdictional limits of the Court.

85. As a further direct and proximate cause of the acts alleged herein, Plaintiffs seek attorney's fees as provided for in California Civil Code Sections 52.1(b) and 52.1(h) in an amount to be shown according to proof at trial.

SEVENTH CAUSE OF ACTION

NEGLIGENCE (BREACH OF MANDATORY DUTY)

(By Plaintiffs A.G., R.O., D.O., B.L., D.L., and N.L against All Defendants)

86. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

87. Defendants had a legal duty to Plaintiffs. Defendants knew of the abuse and misconduct occurring in the Barron home, yet failed to take appropriate action to investigate and stop the abuse. Defendants received numerous reports and complaints about the Barron home and the suspected abuse of the minor Plaintiffs and decedent. However, Defendants failed to properly and/or adequately investigate the complaints and repeatedly failed to take appropriate action as mandated by the Welfare and Institutions Code sections and/or Department of Social Services ("DSS") regulations set forth below.

88. Defendants County and DOES 1-50, despite receiving numerous reports and evidence of abuse and neglect of minor Plaintiffs and decedent, negligently investigated these reports, failed to develop a mandatory "case plan", and failed to place a "300 hold" on the children, pursuant to Welfare and Institutions Code Section 300, et seq.

89. Defendants failed to investigate or otherwise respond to the reported instances of child abuse and/or neglect of minor Plaintiffs and decedent as mandated by Welfare and Institutions Code Sections 328, 16504(a), 16501(d), and/or 16501(f), and/or DSS Regulations 31-101, 31-105, 31-110, 31-115, 31-120, and/or 31-125.

90. Welfare and Institutions Code Section 328 states, "The social worker shall interview any child four years of age or older who is the subject of an investigation to ascertain the child's view of the home environment. DCFS made visits to the Barron home in which social workers did not interview Anthony or his half-siblings that were four years and older.

91. Welfare and Institutions Code Section 16501(f) states, "County welfare departments shall respond to any report of imminent danger of a child immediately." There are countless instances of Anthony and his half-siblings being in imminent danger and there was no immediate response from social workers. Additionally, some referral were emergency referrals and social workers failed to see or speak to the children the day of the referral.

92. DSS Regulation 31-101 states DCFS workers need to be skilled in "emergency response". The social workers responding to the Barron home regarding referrals made about child abuse against Anthony and his half-siblings were not skilled in this area. There is evidence that even referrals designated emergency referrals were not properly responded to by social workers, and sometimes were not responded to at all.

93. DSS Regulation 31-105 states that a social worker shall immediately initiate and complete the Emergency Response Protocol process when it is necessary to determine whether an in-person investigation is required. Furthermore, the social worker shall record all available and appropriate information on the Emergency Response Protocol form SOC 423 (10/92), or an approved substitute. DCFS social workers repeatedly failed to fill out the requisite forms in the instant case, including, but not limited to, SOC 423 Form (10/92).

94. DSS Regulation 31-115 dictates that among the factors in determining the need for an in-person investigation, is when allegations and/or behavioral indicators which are suggestive of abuse, neglect, or exploitation. Here, DCFS social workers failed on multiple occasions to follow this, which amounts to statutory breach of a mandatory duty.

95. Defendants failed to accept reports of suspected child abuse and/or neglect of minor Plaintiffs and decedent without legal justification and did not properly maintain a record of all reports received as mandated by Penal Code

section 11165.9. DCFS violated their statutory duty by refusing to accept a case of reported child abuse related to Anthony and his siblings on more than one occasion. DCFS's failure to take a report is even more egregious than the act itself of refusing to accept a report. There is a recording of a call reporting abuse where the social worker is actually laughing at the allegations of abuse. This nonchalant attitude by the recipient of the report shows the complete disregard DCFS employees had for the safety of the children they were employed to protect. It further shows the lack of training and supervision that existed within an agency where an employee can laugh off a report alleging abuse of a child and consequently not accept it.

96. As "mandated reporters" under Penal Code sections 11165.7(a)(15) and (18), Defendants failed to report suspected child abuse and/or neglect of minor Plaintiffs and decedent to appropriate authorities and failed to make initial reports or follow up reports within 36 hours of receiving said reports of abuse and/or neglect as mandated by Penal Code sections 11165.9 and 11166(a).

97. Defendant negligently delivered child protective services of minor Plaintiffs and decedent by failing to properly conduct an assessment and develop a case plan as mandated by DSS Regulations 31-201, 31-205, 31-206, and/or Welfare and Institutions Code section 16501.1(d).

98. Even though said Defendants received various reports of abuse and/or neglect of minor Plaintiffs and decedent, and observed some of the abuse and/or neglect themselves, Defendants failed to conduct a basic evaluation of risks to determine whether an emergency situation existed as mandated by Welfare and Institutions Code section 16504 and/or DSS Regulations at 31-101, 31-105, 31-110, 31-115, 31-120, and/or 31-128.

99. Despite Defendants receiving numerous reports of abuse and/or neglect of minor Plaintiffs and decedent from multiple sources, and observing some of the abuse and/or neglect themselves, Defendants failed to control the conduct of

Heather Barron and Kareem Leiva, and/or otherwise protect minor Plaintiffs and decedent as mandated by Welfare and Institutions Code sections 16504(a), 16501(d), and/or 16501(f).

100. These negligent and reckless acts and omissions were a substantial factor and a legal cause of the damages and injuries sustained by minor Plaintiffs and decedent, and the legal cause of decedent's death as alleged in this complaint. Had Defendants fulfilled their mandated and legal duty of care, minor Plaintiffs and decedent would not have been harmed and decedent would not have been murdered.

101. Additionally, under California Evidence Code section 669, the negligence of Defendants, and their employees or agents, may be presumed for the reason that:

a. Defendants, and each of them, violated the child protection statutes, placing minor Plaintiffs and decedent in harms way pursuant to California Penal Code section 273(a) (Endangerment) and failing to investigate reports of child abuse;

b. The violations proximately caused injury to minor Plaintiffs and decedent;

c. The injuries to minor Plaintiffs and decedent were occurrences of the nature which the statutes are designed to prevent; and

d. Minor Plaintiffs and decedent were members of the class of persons for whose protection these statutes were adopted.

102. As a direct and proximate result of the acts and omissions of Defendants, including its employees or agents, and each of them, as alleged herein, minor Plaintiffs and decedent suffered injuries including, but not limited to, physical and mental pain and suffering, physical injuries, past and future costs in medical care and treatment, and past and future loss of earnings capacity, in an amount not yet ascertained, but which exceeds the minimum jurisdictional limits of the Court.

103. As a direct and proximate result of the act and omissions of Defendants, including its employees or agents, and each of them, as alleged herein, Avalos and minor Plaintiffs suffered the loss of companionship of Anthony Avalos.

EIGHTH CAUSE OF ACTION

GROSS NEGLIGENCE

(By Plaintiffs A.G., R.O., D.O., B.L., D.L., and N.L against Hathaway)

104. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

105. As stated above, Defendant Hathaway acted negligently and with willful disregard towards Plaintiffs. It had a duty of care that it breached, which was the actual and proximate cause of Plaintiffs' injuries.

106. In doing each and all of the acts and omissions herein alleged, Hathaway engaged in a course of conduct which was grossly negligent, extreme and outrageous. Hathaway engaged in said course of conduct with wanton and reckless disregard of the consequences or harm that was likely to result to minor Plaintiffs and decedent.

107. Hathaway assigned employee Barbara Dixon to work with the Barron family after it had actual knowledge that, despite being a mandated reporter, Ms. Dixon had in the case of Gabriel Fernandez, another child who was killed while under DCFS' care, consciously, intentionally, and willfully not reported abuse of Fernandez by his mother and her boyfriend. Ms. Dixon is and was a mandated reporter under Penal Code section 11165.7(a)(15) and (18) that intentionally violated her duties under the code section to report child abuse, this is a crime.

108. Additionally, Hathaway has a policy of having supervisors discourage the reporting of child abuse in violation of mandated reporter laws. Ms. Dixon

testified, after being granted immunity, under oath in the Gabriel Fernandez case, that she had been told by her supervisor not to make a report regarding the abuse of Gabriel Fernandez.

> Q: So one of those requirements was that when you observed injuries, you were to call the DCFS hotline; is that correct?
> A: I was to discuss it with my supervisor.
> Q: You believed that your duties as a mandated reporter were to discuss it with your supervisor?
> A: Correct.
> Q: Not to call 911 or the DCFS hotline?
> A: Correct.
> Q: And was that your custom and practice while working at Hathaway Sycamore?
> A: Yes.
> Q: So whenever you observed injuries on a case that you - - whenever you observed injuries on a child abuse case you were servicing, you would first discuss with your supervisor whether this was something that needed to be reported to the DCFS hotline?
> A: Correct.
> Q: So if your supervisor said, 'Ms. Dixon, don't report these injuries to the hotline,' you follow that directive?
> A: Correct.

109. Despite all this, Hathaway, continued to employ Ms. Dixon to work with children and assigned her to work with decedent, knowingly placing them in harm's way. Hathaway's actions in the Fernandez case and its aftermath placed Anthony directly in harm's way. Defendant Hathaway should have immediately removed Ms. Dixon following her preliminary hearing testimony and conducted an audit of all the cases she had been assigned to in order to see if there were other occasions where she failed to report suspected child abuse.

110. The conduct of Defendant Hathaway was willful, malicious, conscious, extreme, outrageous, and warrants the imposition of punitive damages against it.

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NINTH CAUSE OF ACTION

NEGLIGENT SUPERVISION

(By Plaintiffs A.G., R.O., D.O., B.L., D.L., and N.L against All Defendants)

111. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

112. At all times mentioned herein, Defendants were under a duty to supervise the conduct of its social workers and employees to enforce those regulations necessary for the proper enforcement of the laws of the State of California and to exercise ordinary care to protect minor Plaintiffs and decedent from abuse as established herein.

113. Defendants were negligence and careless in that they failed to properly train and supervise its employees. Furthermore, Defendants negligently entrusted its employees or agents with exercising the laws for the protection of minor Plaintiffs and decedent.

114. Defendants negligently failed to supervise their employees appropriately so as to prevent the type of violations of policy and statutory laws and regulations as alleged herein that led to the injuries sustained by minor Plaintiffs and the death of Anthony Avalos.

115. Defendants negligently failed to supervise their employees so as to prevent the types of incidents herein alleged, failing to properly train and to supervise the training of its employees or agents about correct manner in which to effectuate the child protection laws enacted to protect minor Plaintiffs and decedent.

TENTH CAUSE OF ACTION

NEGLIGENT HIRING AND RETENTION

(By Plaintiffs A.G., R.O., D.O., B.L., D.L., and N.L against All Defendants)

116. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

117. As agencies working with children, DCFS and Hathaway were entrusted with the care of minor children within their system.

118. At no time during the periods of time alleged did Defendants have in place a system or procedure to reasonably investigate, supervise, and monitor its employees.

119. At no time during the periods alleged did Defendant County have in place a system or procedure to reasonably investigate, monitor, or supervise Hathaway, one of its largest agents used to provide mental health services to children and their families within the DCFS system.

120. Defendants were or had reason to be aware of and understand how vulnerable children are to sexual and physical abuse.

121. Defendants were put on notice, and had reason to know that Hathaway employee Barbara Dixon and her supervisor, had previously engaged in dangerous and inappropriate conduct, and that it was, or should have been foreseeable, that they would engage in dangerous and inappropriate conduct again.

122. DCFS knew of the pattern of Hathaway to violate mandatory reporting laws. Dixon herself testified in a preliminary hearing in the Gabriel Fernandez case that she it was the custom and policy of Hathaway and herself not to report child abuse and in fact she did not report the abuse she observed of Gabriel Fernandez and was directed to do so by her supervisor. Despite knowing this, DCFS continued to contract with Hathaway, and even had Dixon assigned to Avalos and his family. To this day, DCFS continued to contract with Hathaway.

123. For its part, Hathaway hired Dixon as a licensed therapist once she received her licensed, post the death of Gabriel Fernandez, and retained her and her supervisor even after her testimony about not reporting child abuse.

124. Defendants' conduct was a breach of their duties to Avalos and his half-siblings.

ELEVENTH CAUSE OF ACTION

VIOLATION OF CIVIL RIGHTS

[California Civil Code Sections 52.1]

(By Plaintiffs A.G., R.O., D.O., B.L., D.L., and N.L against County of Los Angeles)

125. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

126. This action is brought pursuant to California Civil Code Section 52.1. This cause of action is to redress the deprivation, under color of statute, ordinance, regulation, policy, custom, or practice of usage, of rights, privileges, and immunities secured by the Constitutions of the United States and California including, but not limited to, the right to be free from violence and threats of violence.

127. Plaintiffs are informed and believe, and thereon allege, that Defendants, and each of them, violated minor Plaintiffs and decedent's civil rights and subjected them to physical violence.

128. During all times mentioned herein, Defendants, separately and in concert, acted under color and pretense of law, under color of the statutes, ordinances, regulations, policies, practices, customs, and usages of the State of California and County of Los Angeles. Each of the Defendants, separately and in

concert, deprived minor Plaintiffs and decedent of the rights and privileges secured to them by the Civil Code as alleged herein.

129. Minor Plaintiffs and decedent were subjected to the deprivations alleged herein as a result of the failure of Defendants to properly train their employees or agents.

130. As a direct and proximate result of the acts and omissions of Defendants, including its employees or agents, as alleged herein, minor Plaintiffs and decedent suffered injuries including, but not limited to physical and mental pain and suffering, physical injuries, past and future costs of medical care and treatment, and past and future loss of earnings and earnings capacity, in an amount not yet ascertained, but which exceeds the minimum jurisdictional limits of the Court.

131. As a further direct and proximate cause of the acts alleged herein, Plaintiffs seek attorney's fees as provided for in California Civil Code Sections 52.1(b) and 52.1(h) in an amount to be shown according to proof at trial.

TWELFTH CAUSE OF ACTION

SURVIVAL ACTION

[California Code of Civil Procedure Section 377.34]

(By the Estate of Anthony Avalos against All Defendants)

132. Plaintiffs reallege and incorporate by reference herein each and every allegation contained herein above as though fully set forth and brought in this cause of action.

133. This cause of action is brought by the Estate of Anthony Avalos, based on violations of his Fourteenth Amendment rights and pursuant to Section 377.34 of the California Code of Civil Procedure.

134. As a proximate result of the conduct of Defendants as alleged, decedent suffered intense physical and emotional pain, anguish, distress, despair, and suffering all during the time of reports of abuse and neglect were made to Defendants and up until the time of his death. The Estate of Anthony Avalos is claiming survival damages under their federal and state law claims.

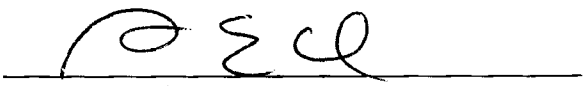
WHEREFORE, PLAINTIFFS pray for a jury trial and for judgment against Defendants as follows:

FOR ALL CAUSES OF ACTION

1. For past, present and future general damages in an amount to be determined at trial, in excess of $50 million.
2. For past, present and future special damages, including but not limited to past, present and future lost earnings, economic damages and others, in an amount to be determined at trial;
3. Any appropriate statutory damages;
4. For punitive damages as to the gross negligence cause of action.
5. For costs of suit;
6. For interest as allowed by law; and
7. For such other and further relief as the court may deem proper.

DATED: July 31, 2019

THE CLAYPOOL LAW FIRM

By: 

Brian E. Claypool, Esq.
Nathalie Vallejos, Esq.
Attorneys for Plaintiffs

DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a trial by jury.

DATED: July 31, 2019

THE CLAYPOOL LAW FIRM

By: _____

Brian E. Claypool, Esq.
Nathalie Vallejos, Esq.
Attorneys for Plaintiffs